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ABSTRACT

Data from the Asian American Field Survey of 1973 were examined to determine health problems, methods of seeking and paying for health services, health insurance coverage, and frequency of medical examinations among Japanese, Chinese, Filipino, Korean, and Samoan families in the United States. The analysis indicated that the Chinese reported the greatest percentage of health problems in families. Among those who reported having health problems, it was found that: (1) problems frequently cited were minor infectious diseases (such as colds and influenza), heart and circulatory problems, and, as reported by Koreans, pregnancy and childbirth; (2) there was a high rate of utilization of health services; (3) barriers to seeking medical care included lack of information, cost of services, language problems, and transportation difficulties; (4) about half of the sample sought medical aid from health facilities while half consulted individual medical practitioners more often; (5) most families were covered by health insurance; and (6) major sources of information about medical care were friends, relatives, and doctors. Among those who reported health problems, slightly more had regular medical examinations than among those who reported no health problems. Sex differences and ethnic group differences on health problems and health services usage were also investigated. The report includes 25 statistical tables. (MJL)

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ASIAN AMERICAN FIELD SURVEY:
RE-ANALYSIS OF HEALTH DATA

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Paper presented at National Association for Interdisciplinary Studies Annual Conference, Las Cruces, New Mexico, April 23, 1981.

The Health Care Alternatives of Asian American Women research project is funded by an NIMH grant. The focus of this research is to find out what is considered health and illness, how and by whom it is defined, maintained, or cured in the Asian American communities of Chinese, Japanese, and Pilipinos in Los Angeles. While women are central to this research, it is not so much as patients but as the primary interpreters of illness and as the health caretakers in the Asian American family.

Although this topic is an important one, the health issues of Asian Americans generally, and Asian American women specifically, have hardly been analyzed. Thien complains:

> "There has never been a nationwide study which has included a meaningful survey regarding the health problems of Asian/Pacific women. Very few systematic empirical studies have been conducted of this population group. In some studies, the health problems of Asian Americans are mentioned only as an afterthought...In addition, the attempt to search and analyze data on Asian American women is made more difficult because even fewer studies deal with this subgroup or break down their data by sex. Furthermore, other factors such as cohort differences, age differences, regional differences, socioeconomic differences in addition to distinctly separated ethnic groups, make generalizations extremely difficult (1980:153)."

In consideration of this lack of solid data in the area of health assessments of Asian Americans and Asian American women, the 1973 Asian American Field Survey offers an invaluable information bank. The Asian American Field Survey was a national HEW survey conducted in 1973 on the characteristics of the Asian American populations living in low-income, urban areas. The objectives of this survey were to assess the needs and services of these groups in the areas of health, education, and welfare. Five ethnic groups in three cities were surveyed: the Chinese in New York, the Pilipinos in San Francisco, and the Japanese, the Koreans, and the Samoans in Los Angeles. The

basic units of interview in the Field Survey included primary nuclear families, subfamilies, and unmarried individuals 18 years of age or over, each of which was treated as a family. A total of 3825 individuals of 1620 families and of 1094 households were interviewed. The data were then coded and placed on computer tapes for analysis (HEW 1977).

Problems with the Field Survey

Despite its attractiveness, the Field Survey is not without problems. First, the sample of the Field Survey was not representative of the U.S. Asian American population. The text of the Field Survey report explains:

> "The universe of the sample comprises those Asian American households located in concentrated clusters in generally low-income areas. Users of the data are cautioned that the sample was not designed to be representative of all urban, low-income, Asian American households. Survey methods necessitated that coverage be limited to households located in ethnic enclaves; thus the data are only generalizable to a population with these specific characteristics (HEW 1977:3."

The report further emphasizes that "the data that were collected were unique and comparable baseline statistics on non-Asian populations are not available (HEW 1977:2)."

Second, there is a data set which is missing: the individual data set. The data of the Field Survey are divided into three sections: the individual data set, the head of family data set, and the health problem data set. The Field Survey report states that "the computer tape itself is on one reel which carries the individual and head of family data set as well as the health problem data set (HEW 1977: D-1)." Unfortunately, this statement is not true. The head of family data set and the health problem data set are on different tapes; and the individual data set is mysteriously

missing. Enquiries have been made to the Division of Asian American Affairs at the Department of Health, Education, and Welfare; as well as to other individuals who were known to have worked on the tapes, but to no avail. To date, we have been unable to locate the individual data set.

A third problem is the separation of the head of family file from the health problem file. The health problem file has only 12 variables: 9 health variables, 1 ethnic variable, 1 migration variable, and 1 case identification number (HEW. 1977: Appendix D-36). Since other important variables are not available in the health problem file, we cannot detect the relationship between health problems and other variables such as sex, age, education, occupation, etc. Consequently, this report of our re-analysis of the Field Survey data is largely confined to simple cross-tabulations. Little multi-variant analyses have been performed.

Fourth, the way that the Field Survey set up the health problem file created problems. The unit of the health problem set is one health problem case. If an individual has one health problem, he/she is represented by one health problem case and such as individual can only answer the questions once. But if an individual has five health problems, he/she is represented by five health problem cases and has answered the questions five times, one for each health problem. In this respect an individual who has many health problems carries more "weight" than one who has only a single health problem. This obviously biases the results somewhat. To illustrate this problem, we can consider the following hypothetical situation. If the Korean population had a large number of children in their sample and these children had multiple cases of the various childhood illnesses in the

previous 12-months so that the average Korean had three health problem cases. Whereas, if the Chinese population did not have very many children with multiple cases of illness so that on the average, Chinese individuals would have only one health problem reported in the last 12-months. This would mean that a Korean "weighs" three times more than a Chinese for any one question in the health problem data set. Figure A illustrates how if we use the individual as the unit of analysis, immigrant status and method of payment are not related.

		Immigrant	
		Yes	No
Method of Payment	Cash	50 Korean	50 Chinese
	Not Cash	50 Chinese	50 Korean

FIGURE A

Figure B shows how, if the health problem case is used as the unit of analysis, and we use our hypothetical example of Koreans averaging three times more health problems than Chinese, we get the erroneous picture that immigrant Koreans are more likely to pay their bills in cash than Chinese immigrants.

		Immigrant	
		Yes	No
Method of Payment	Cash	50 x 3 Koreans	50 Chinese
	Not Cash	50 Chinese	50 x 3 Koreans

FIGURE B

Finally, there were minor problems such as miscoding of variable categories (e.g., age re-grouped, immigration year grouped), duplication of health problem cases by punching errors, lack of codebook information on the meaning of some variables (e.g., columns 3-9 in the health problem file are left unexplained), and so forth.

Efforts of Solve the Problems of the Field Survey

Since the Field Survey is the only large-scale social survey thus far specifically carried out on the needs and problems of Asian Americans, it cannot be dismissed out of hand simply because of its problems. Therefore, we attempted to solve the problems of the Field Survey data sets in the following manner.

First, the health problem data set was merged into the head of family data set. Using the add variable procedure of the Statistical Package for the Social Sciences (Nie et al. 1977), the variables of the health problem data set were combined with the head of family data set, creating a new SPSS file which contains 1620 cases and 331 variables. The procedures of merging the two data sets are described in So (1980). With the increase in variables from 9 to 331, multivariant analyses can be performed on the health problem data set.

Second, the unity of the new SPSS file is not longer a health problem case but the family. In the original questionnaire, most of the questions on health problems were asked on the basis of the family unit. For example, one of the questions was, "What were the major health problems of the family during the past year?"

Third, since it is the head of the family who usually answers the questionnaire, responding for the whole family, and since the available data set provides demographic, social, and economic

information on the head of the family, the head of the family can be treated as an individual and his or her health problems and behaviors can be analyzed accordingly. In this respect, the head of family data set, if used with care, can provide analysis on two levels: one about the whole family, the other about the head of the family as an individual. Since we do not have the individual data file of the Field Survey, we used this merged file. This merged file of 1620 family heads became one of our working samples. It will be referred to as the Family Heads Sample (FHS). We also developed a second sample of health problem families which numbered 731. These were families in the FHS who had at least one health problem reported in the 12-months prior to the administration of the interviews. This sample is called the Health Problems Sample (HPS).

The reason we pulled out those families with reported health problems was to get a better idea of what happens to those people who have health problems for which they desire care, how they are discouraged from it, where they go, and what type of care they may need.

First, the demographic and socio-economic background of the FHS will be summarized, followed by selected health problems results. The HPS will be presented in the health problems sections.

Demography and Socio-Economic Background of FHS:

The ethnic breakdown of the 1620 heads of families in the FHS was: 25% Chinese, 23% Japanese, 16% Korean, 18% Pilipino, and 17% Samoan. Obviously, this is not a representative distribution of these groups in the United States. However, it is not known if

this is representative of the distribution of these groups in this age or socio-economic bracket or of this immigration status.

In general, the FHS was composed of mostly male (73%), foreign-born (90%), recent immigrants (55% came between 1966-1973) and speakers of an Asian language as their primary language (92%). Table 1 gives a breakdown of this information by ethnic group. Chinese and Japanese were considerably older than the other three groups. The median ages for each of the five groups does appear to be reflective of the immigration trends of these groups, with the Chinese and Japanese having an older immigrated group and the Korean, Pilipino, and Samoan having more recent, large scale arrivals. Also note that the Japanese group has the largest percentage of women in the Family Heads Sample. It is further apparent by Table 1 that the Korean group appears to be the best educated and the most prosperous of the five groups. Although one could hardly consider an average monthly income range of $449 to $522 as being prosperous. While the total range of incomes are not given, we found that 11% reported having $0 income.

Therefore, this sample is composed of primarily low-income, middle-aged or elderly family heads living in major urban centers.

While this sample may not represent the whole Asian American population, it serves to sensitize us to certain aspects of these elderly and long-time resident Asian Americans. It would be interesting to see how this group compares with the more recent, particularly post-1975 Asian immigrant population. The data from the Field Survey and the population sample it touches are reminders that for a substantial proportion of Asian Americans, particularly for the elderly and previous generation of immigrants, ghetto existence and

chronic conditions of poverty remain their only way of life. This examination of their health problems, their patterns of seeking care, their method of paying for health services, and their commitment to health insurance and medical examinations offers an important comparative perspective from which to view the new Asian immigrants of the last 10 years.

Selected Health Problems Results

Reported Prevalence of Major Health Problems: The Field Survey defined a major health problem as being: "...an acute illness or an accident which occurred during the preceeding 12-months which was serious enough to warrant seeking help from a professional person, or a chronic illness or handicapping condition" which either began or continued in the last 12-months (HEW 1977:B-6).

Almost half of the families in our Family Heads sample reported at least one major health problem within the 12-months preceeding the 1973 Field Survey and a fifth of our sample families were reported to have had two or more major health problems. Among the five ethnic groups, the Chinese reported the largest percentage of health problems in a family. Whereas the Koreans reported the lowest average of health problems per family. (See Table 2.) However, overall, this was a pretty healthy group in terms of reported illnesses that required medical treatment. According to Table 2, 55% of the FHS had reported no health problems in the previous 12-months. When the families are broken down by the sex of the Family Heads, (Table 3) there is no significant difference between the number of health problems reported for families with male heads versus families with female heads.

However, there is a significant difference in health problems reported for male heads of families and for female heads of families for themselves. Women had significantly more health problems reported for themselves than the male heads of families reported for themselves. (x^2=25.5, df=2, $p < 0.01$) (See Table 4.)

When only the families that reported at least one health problem are considered, the above pattern is held consistent. There were no significant differences between the male headed families who reported at least one health problem and the the female headed families who reported at least one health problem. (See Table 5.) Whereas there is significant difference between the number of health problems reported for male and for female family heads. For those families who reported health problems within the 12-months prior to the interview, 96% of the female family heads reported one or more incidents of personal health problems while 72% of the male heads reported one or more. This difference was significant at the 0.001 level (x^2=57.5, df=2). (See Table 6)

The remainder of the data reported here will be concerned with only those family heads who reported health problems in their families. This is the Health Problems Sample (HPS). Where there was sufficient data, we did attempt to break the figures down by sex and/or ethnic groups. Also, while most of the tables will give information on all five ethnic groups sampled by the Field Survey, the text and tests of significance will refer only to the Chinese, Japanese, and Pilipino samples since those are the target groups of this research project. Also, some tests of signficance were done for grouped data including all five ethnic groups and for male/female differences. More detailed breakdowns

were precluded by cell frequencies which were too small for statistical analysis.

Table 7 gives a comparison of the demographic differences of the FHS as compared to the Health Problems Sample and the non-Health Problems Sample which make up the FHS. Overall, the HPS is older, poorer, immigrated earlier, less likely to speak English, and less well-educated than the FHS as a whole and as compared to the non-Health Problem Sample. The Japanese Health Problem Sample is rather different from all the other groups, being considerably older, having a larger percentage of females, U.S-born individuals, and people who immigrated before 1966. They also are more likely to use English as their primary language than, not only the other ethnic groups, but also the FHS and the non-HPS of Japanese.

Type of Major Health Problems Reported: The types of health problems reported differed across ethnic groups. For the Chinese, the most frequently cited major health problem was minor infectious diseases such as colds and influenza (32%). For the Japanese, it was heart and circulatory problems (24%) and for the Pilipinos, it was both minor infectious diseases (19%) and heart-circulatory problems (18%). Table 8 gives a detailed breakdown of the health problems reported for the five ethnic groups. An interesting result for the Korean sample was that one of the major health problems reported was pregnancy-childbirth (15%). This was reported not by female family heads but in all cases were reported by Korean married male heads of households between the youthful ages of 26 to 35 years of age.

Utilization of Health Services: Of those family heads who

reported health problems in their families, nine out of ten sought medical health care. (Table 9) However, this high rate could be misleading since the question asked by the interview schedule precluded this response. The question asked for health problems which required professional help.

Barriers to seeking help for the 11% who did not seek medical care in spite of a health problem were mainly lack of information about where to go (30%), high cost (25%), language problems (23%), and transportation difficulties (10%). The Pilipino sample differed from this overall pattern by stressing the lack of information much more (65%) and complicated procedures (22%). (See Table 10)

Once individuals sought help and were in the health care system, approximately 39% encountered difficulties with Samoans reporting the largest percentage of difficulties (58%) and the Japanese the least (26%). (See Table 11a.) The major difficulty at this point was not language (2%) despite the fact that 93% reported an Asian primary language. Nor was it transportation (1%). But it was high cost. An overwhelming 97% of those who encountered difficulties cited the monetary factor (Table 11b.)

Source of help was almost evenly divided between going to a facility (54%) and going to a practitioner (46%). However, it is not clear from the questionnaire or the coding instructions of the Field Survey if an individual could use both a facility or a practitioner for a single illness. Therefore, we re-analyzed these results and found that 21% of those who sought help gave a double answer for each incident of illness. In other words, 21% said that they used both a facility and a practitioner for one

illness episode. Therefore, we reclassified the data into three categories of sources of help: (1) Practitioner Only, (2) Facility Only, and (3) Both Practitioner and Facility. The overall percentage totals were: Practitioner Use Only, 44%; Facility Use Only, 28%; and Use of Both Practitioner and Facility, 27% (Table 12).

Using a chi-square, there was a significant difference between the Chinese, Japanese, and Pilipino use of only a practitioner, only a facility, or both a facility and a practitioner for a single illness case ($x^2=96.42$, df=4, $p< 0.001$). (See Table 12.) Chinese and Japanese use only a practitioner much more than Pilipinos whereas Chinese and Pilipinos use only facilities much more than Japanese. Regarding the use of both a facility and a practitioner for one illness case, over 40% of the Pilipinos reported the dual use. Roughly, this gives us a picture of the Japanese being strongly inclined toward practitioner use, the Pilipino toward facility and dual use, and the Chinese somewhat in between the other two groups. These results raise a provocative question of what order or hierarchy of choice, either voluntary or forced, was made about where to go to seek medical aid. In Table 13, all five ethnic groups are presented in terms of these three options for source of care. Note the similar Samoan and Korean pattern of almost exclusively using the dual mode of facility and practitioner for each case of illness.

A final word on this question of source of medical care; it is unclear if, when a respondent stated they went to a private doctor, they were questioned by the interviewer to insure they did not mean a private doctor trained in Chinese medicine, Japanese medicine or an alternative form of medicine (osteopathy, homeopathy, chiropractic). This may account for the low frequency of only

2% reporting having gone to an acupuncturist or an herbalist, which were the only coding possibilities for alternative practitioners.

An interesting pattern is evident in the types of facility use exhibited by the Chinese, Japanese, and Pilipino groups. Considering all responses of facility use (i.e., both those given as only facility use and as facility use in conjunction with practitioner use), overall, 82% of the three groups went to a hospital and 18% went to a non-hospital facility, such as a community clinic. There was a significant difference between all three groups using a chi-square ($p < 0.05$). Japanese use hospitals the most and non-hospitals the least, while Pilipinos reverse this pattern. The Chinese again rank between both groups in their use pattern. (Table 14)

However, when these categories are broken down further so that hospital use is distinguished by inpatient and outpatient care, a more important pattern emerges, giving more detail about the different health care actions and/or needs of these three groups. Looking at Table 15, it is quickly apparent that the Japanese group has an overwhelming 64% use of inpatient care, as compared to the 37% and 29%, respectively, of the Chinese and Pilipino sample. The significance of this difference is much higher than in Table 14, with $p < 0.001$. This seems to indicate that the Japanese who use these facilities are suffering from more hospitalizable or acute cases of illness or injury; or they delay care until it become acute. We are presently conducting analyses to see which illnesses are associated with the types of facility use.

For the Pilipino sample, obviously, non-hospital facilities are more important as a source of health care than for the other

two groups. Fully 24% of the Pilipinos used non-hospital facilities. In order to better understand the specificities of this use, we broke down the non-hospital use into types of facilities used. In Table 16, one can see that for Pilipinos, 18% used a community center and 5% used a health center. This seems to indicate the importance of local health care centers for Pilipinos.

Presently, we only have the figures for these three groups.

Method of Payment: A vast majority of the HPS had someone in their family covered by insurance. It was reported by 82% of those families who had health problems that someone was covered by insurance (Table 17). Unfortunately, it was not specified who was covered by the insurance. So we do not know if the people who had a health problem in the last 12-months were the same who had the health insurance coverage. This is a regretable situation since we do have the report that 37% used their personal savings to pay for medical services and only 49% used insurance (Table 19). (Table 20 gives the types of insurance held by each of the five ethnic groups.) If we had been able to match insurance coverage with method of payment, we might have been able to detect some interesting patterns. For example, it would have been useful to know if despite a high percentage of insurance coverage, there was a low use of it to pay for medical expenses. However, without knowing the vital bit of information i.e., if the individual who was ill was the same person covered by the insurance, we cannot make any judgment as to the relationship between these figures.

Process of Referral, Discovery of Health Care Services: Overall, the major sources of information were friends (48%), relatives (21%)

and doctors (13%) as can be seen in Table 20. Public media, nurses, Asian vernaculars, outreach workers were not important sources. However, in an initial research investigation of this project on ads of practitioners in Asian vernaculars, there is a vigorous advertising campaign conducted by medical and alternative practitioners in Japanese and Chinese language newspapers which belies the result in the Field Survey on vernaculars. It points to perhaps the lack of overlap between those using Western health care and those using non-Western methods. When one looks more closely at the ethnic differences of referral sources, one finds Chinese, Pilipinos and Koreans depending primarily from friends; Samoans on relatives and Japanese on doctors. Looking at the breakdown by sex, the men depend primarily on friends (52%) while the women are evenly divided between friends and relatives as sources of referrals. This was a significant difference of $p < 0.001$. (See Table 21.) If we break down the source of referral by sex within ethnic groups for the Chinese, Japanese, and Pilipinos, we find the basic sex differences holding for Chinese and Pilipinos but differing for Japanese. Japanese men were primarily referred by M.D.'s (37%) and evenly divided between referrals by friends (24%) and relatives (24%). In comparison, Japanese women's primary referral source was relatives (36%) with physicians second (33%). Friends account for only 14% of their referral sources. See Table 22a. In Table 22b are summarized the Korean and Samoan sex differences. While the Koreans look very similar to the general sex difference pattern of referral sources and the Samoan women look very much like the Japanese women, the Samoan men have a unique pattern of distribution between friends, relatives and physicians.

Preventative Health Care: A final set of tables (Tables 23, 24, and 25) compares the conventional measures of preventative health care, regular check-ups. Comparing the Health Problem Sample with the non-Health Problem Sample we found some interesting differences. There was a significant difference ($p<0.01$) between the HPS and the non-HPS in the recency of medical check-ups. (Table 24) However, again, this was precluded by the distinguishing characteristic of the health problems sample which was having a health problem which required medical care in the 12-months prior to the interview. There was no significant difference in the two groups in the recency of eye check-ups (Table 24). The two groups did differ significantly ($p < 0.05$) on recency of dental check-ups with the non-health problem sample having more recent dental check-ups than the health problem sample. It is notable, however, the large percentage in both groups of people who reported never having had a dental examination (HPS, 29%; non-HPS, 26%). (See Table 25.)

DISCUSSION

The significance of these results is limited by the problems discussed earlier. However, they do point out certain areas of significance in health behavior which are consistent with other research findings on Asian Americans.

First, an important first stage barrier to getting medical care was the lack of information (30%). High cost (25%) and language problems (23%) were also important first stage barriers. This is consistent with other studies (U.S. Commission on Civil Rights 1980, Iwataki 1979, Taran 1976). However, few have considered the problems encountered once the individual gets into the health care system. In our re-analysis of the Field Survey, we found that

a second stage barrier exists of high cost (97%). This seems to indicate that once someone has decided that they want Western medical care, language, transportation and other barriers become secondary; it's the high cost of medical care that acts as a deterrant (Navarro 1973, 1976, Sidel and Sidel 1977).

Second, the variation in facility versus practitioner use points up very different patterns for the Japanese and for the Pilipinos. Weaver (1976) found strong evidence of this Japanese preference for private practitioners, and private practitioners of Japanese ancestry. He also found the Pilipino pattern of facilities preference. He attributes this to the fact that Pilipino practitioners are more likely to be found at a facility than in private practice. Therefore, Pilipinos might feel that their chances of getting a medical practitioner of like ancestry would be greater at a facility than in private practice. This distribution of Pilipino practitioners has been confirmed by the President of the Philippine Medical Society of Southern California (Quevedo 1980). Also, the significantly higher use of inpatient facilities by Japanese seems to lend support to other research on their delay of mental health needs because of the fear of stigma (Kitano 1969) and consistent with the Japanese stoic value of gaman where to give in too easily to illness would indicate a lack of character.

Third, the referral system of the Health Problems Sample indicates the Chinese and Pilipinos depended primarily on friends, as did the Koreans. The Samoans seem to rely more on relative referrals and the Japanese depended primarily on physician referrals. The importance of the Japanese/physician relationship is explored

by Weaver(1976).

Looking at the sex differences, particularly for the Japanese, one finds the Japanese men consistent with the physician referral mode but the women relying primarily on relatives. This is consistent with Yanagisako's work on the difference between kin and friend networks of Japanese-American husbands and wives (1977).

This information about the various referral systems is important to the planning of appropriate educational and various other outreach programs about health services. It is clear that the focus should be more on community and interpersonal networks than health agencies or facilities.

These first three areas of barriers, usage, and referral show a clear ethnic difference between Asian American groups and the referral systems show a distinct sex difference. This indicates not only considerable variation between Asian American ethnic groups, a large portion of whom havebeen long-time residents in American society, but also within groups by sex.

The sex difference within groups brings up a fourth area highlighted by our re-analysis of the Field Survey. This is in the area of female health problems. The fact that female heads of families reported sigificantly more problems than male heads bears further investigation. Homma-True (1976) has noted female heads of households seem to be more "at risk" than male heads in terms of cultural and psychological stresses. Hirano (1980) discusses some of the structural and social stresses of un- or under-employment, lack of child care and inaccessible health care, particularly maternal and family planning services. This inaccessibility of maternal-family planning services may be a clue to why Koreans most frequently cited pregnancy-childbirth as a major health problem. However, it

unknown if this is a result of pregnancy-childbirth complication. if pregnancy-childbirth is considered an illness, or if there are problems with an excess or lack of fertility for Koreans. A further unknown is why this was reported exclusively by young married males. Thein (1980:160) offers some possible meanings of pregnancy-childbirth for Asian American women. But currently, this remains a speculative area which needs further investigation.

Fifth, there are indications that those Asian Americans who use Western health care practitioners and facilities, do not use alternative practitioners. Only 2% (N=6) of those who sought help for medical problems went to an alternative practitioner, according to the Field Survey interviews. This sparse use pattern was also reported by Taran (1976) for New York Chinese using a neighborhood clinic. This low reported use of alternative practitioners, however, may not be an accurate assessment of alternative health care use since this is a self-selected sample that has come to a Western system, perhaps for a very specific reason. Also, many people would hesitate to admit use of what may seem "backward" practices to outsiders or they may not want to hurt the feelings of the Western practitioner or institutional representative by telling them of a competitive usage. As discussed by Clement (1974), we cannot assume the various types of health care resources (Western, non-Western; lay therapies; home remedies) are functionally equivalent for culture members. Huang and Grachow (1974) indicate that for Chinese-Americans there is a very specific use of Western health care -- for the alleviation of acute problems or emergency injury and only for the alleviation of immediate symptoms. This is what Clement describes as "the association of particular illnesses with particular health resources

(1974:19)." These factors need to be investigated as possible influences in the underutilization of health facilities by Asian Americans.

This brings us to the sixth and final point. That is the uninvestigate question of, "What is health?" or its corrolate, "What is illness for Asian Americans?" As shown by the differences in self-report of what was considered to be a major health problem, this varied considerably across ethnic groups. The Chinese stating most frequently that it was minor infections; the Japanese, heart-circulatory problems; and the Pilipinos, both. This raises the question of whether this was representative of a personal assessment of what was considered a "major health problem" which needed Western medical attention or was it a report of a diagnosis by a specialist? And if so, was it a diagnosis of a Western or non-Western specialist, a lay healer or a relative? What is accounting for the differences between groups?

Continuing research by this project using ethnographic methods and questionnaires will focus on answering the questions of what is considered health and illness, how and by whom it is defined, maintained and cured in the Asian American communities of Chinese, Japanese, and Pilipinos in Los Angeles. We need to know: (1) how people define illness, then (2) on what basis do they decide they are sick enough to seek help, and (3) what methods of remediation they undertake and in what order before we can offer informed suggestions on how to make health care services culturally and structurally more accessible to Asian Americans.

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Table 1. Demographic and socio-economic characteristics of Family Head Sample.

Total Family Heads	Chinese	Japanese	Korean	Pilipino	Samoan
Number	402	377	261	304	276
percentage of 1620 (N)	25%	23%	16%	18%	17%
Median Age in years	45	55	35	35	35
% Male	79%	62%	80%	75%	71%
% Immigrated 1966 and after	47%	14%	94%	67%	53%
% Immigrated before 1966	48%	49%	6%	30%	41%
% Native Born	4%	37%	0%	3%	6%
% English primary language spoken	0%	31%	0%	3%	7%
% Eng. secondary lang. spoken	44%	42%	82%	87%	82%
% Do not speak any English	56%	36%	17%	12%	12%
Median schooling completed (yr)	8-	some hs	college	hs	some hs
% 8th grade or less	66%	40%	16%	28%	30%
% College Graduate	4%	9%	58%	21%	21%
% prof./managers	2%	17%	27%	3%	5%
% laborer/service workers	41%	15%	14%	34%	29%
Median Family income/month	$230-302	$303-375	$449-522	$303-375	$303-375

Table 2. Number of health problems in a family for family heads sample.

#	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
0	43%	52%	65%	57%	65%	55%
1	20	27	22	17	11	20
2	17	13	10	8	7	11
3	10	5	2	6	3	6
4	6	2	1	3	4	3
5	3	2	0	3	6	3
6 or more	2	0	0	7	5	3
Total (N)	101% (404)	101% (372)	100% (261)	101% (303)	101% (274)	101% (1614)

Table 3. Number of health problems in a family by sex (for family head sample).*

#	Male	Female	Row Total
0	55%	55%	55%
1	20%	17%	19%
2 or more	25%	28%	26%
Total (N)	100% (1187)	100% (433)	100% (1620)

* for df=2 chi square=2.1, not significance at 0.05 level.

Table 4. Number of heath problems for a family head by sex (for family head sample)*.

#	Male	Female	Row Total
0	67%	57%	64%
1	25	28	26
2 or more	8	15	10
Total (N)	100% (1187)	100% (433)	100% (1620)

* for df=2 chi square=25.5, significance at 0.01 level.

Table 5. Number of health problems in a family by sex (for health problem sample)*.

#	Male	Female	Row Total
1	45%	38%	43%
2 or more	56	62	57
Total (N)	101% (538)	100% (195)	100% (733)

* for df=1 chi square=2.29, not significant at 0.05 level.

Table 6. Numbers of health problems for a family head by sex (for health problem sample)*.

#	Male	Female	Row Total
0	28%	4%	21%
1	55	62	57
2 or more	17	34	21
Total	100%	100%	99%
(N)	(535)	(196)	(734)

* for df=2 chi square=57.5, significant at 0.001 level.

Table 7. Demographic and socio-economic characteristics of family head sample (comparing its health problem sample and non-health problem sample).

Number of family heads	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total %	Row Total N
A. Family head sample	25%	23%	16%	18%	17%	99%	1614
B. Health problem sample	32%	25%	13%	17%	13%	100%	731
C. Non-health problem sample	20%	22%	19%	20%	20%	100%	883
Median Age (in years)							
A. Family head sample	46	56	36	35	32	41 years	
B. Health problem sample	53	71	40	40	44	51 years	
C. Non-health prob. sample	44	43	35	32	27	35 years	
% Male							
A. Family head sample	79%	62%	80%	75%	71%	73%	
B. Health problem sample	81%	59%	83%	73%	73%	73%	
C. Non-health prob. sample	77%	64%	79%	77%	70%	73%	
% Native Born							
A. Family head sample	4%	37%	0%	3%	5%	11%	
B. Health problem sample	3%	27%	0%	4%	4%	9%	
C. Non-health prob.sample	5%	46%	0%	3%	6%	13%	
% Immigrated before 1966							
A. Family head sample	49%	49%	7%	30%	42%	37%	
B. Health problem sample	55%	67%	10%	34%	46%	47%	
C. Non-health prob.sample	42%	33%	5%	26%	39%	29%	
% Immigrated 1966 or after							
A. Family head sample	47%	14%	94%	67%	53%	52%	
B. Health problem sample	42%	6%	90%	62%	50%	44%	
C. Non-health prob. sample	53%	21%	95%	71%	55%	58%	

Table 7. (Cont'd)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total (%)
% speak English as primary language						
A. Family head sample	0%	31%	0%	3%	7%	9%
B. Health problem sample	0%	22%	0%	3%	6%	7%
C. non-health prob.sample	1%	39%	1%	3%	7%	11%
% speak English as secondary language						
A. Family head sample	44%	41%	82%	88%	81%	64%
B. Health problem sample	37%	36%	76%	86%	75%	55%
C. Non-health prob.sample	54%	47%	86%	88%	85%	71%
% do not speak English as second language						
A. Family head sample	56%	59%	18%	13%	19%	34%
B. Health problem sample	63%	64%	24%	14%	25%	45%
C. Non-health prob.sample	46%	53%	14%	12%	15%	29%
Median schooling completed in years						
A. Family head sample	8-	some hs	col.grad	hs grad	some hs	some hs
B. Health problem sample	8-	some hs	col.grad	hs grad	some hs	some hs
C. Non-health prob.sample	8-	hs grad	col.grad	hs grad	some hs	hs grad
% 8th grade or less						
A. Family head sample	65%	40%	16%	27%	30%	38%
B. Health problem sample	68%	46%	14%	36%	45%	47%
C. non-health prob.sample	62%	34%	17%	20%	22%	31%
% College graduate and graduate school						
A. Family head sample	4%	9%	59%	21%	1%	17%
B. Health problem sample	4%	7%	62%	21%	2%	15%
C. Non-health prob.sample	4%	11%	57%	20%	1%	18%

Table 7. (Cont'd)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
% of professionals and managers						
A. Family head sample	2%	17%	28%	3%	5%	11%
B. Health problem sample	2%	10%	31%	2%	4%	8%
C. Non-health prob.sample	3%	24%	26%	4%	6%	13%
% of operators, laborers, and service workers						
A. Family head sample	50%	24%	31%	43%	54%	39%
B. Health problem sample	49%	18%	30%	36%	54%	37%
C. Non-health prob.sample	51%	28%	30%	46%	53%	41%
Median income/month in $						
A. Family head sample	261	337	485	338	338	
B. Health problem sample	262	260	536	337	332	
C. Non-health prob.sample	125	339	484	339	338	

Table 8. Types of health problems reported (for health problem sample).

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
major infectious disease	1%	2%	0%	4%	3%	2%
minor infectious disease	32	2	5	19	12	16
heart-circulatory	9	24	3	18	14	14
blood disorders	2	0	1	2	1	1
skin disorders	1	1	2	2	0	1
lung chest disorders	10	6	4	9	7	8
nervous system disorders	3	2	2	2	2	2
kidney-genito urinary	1	3	2	0	0	1
endocrine gland	3	9	4	5	0	4
pregnancy-childbearing	3	0	15	1	2	3
digestive system	8	14	12	8	3	9
dental problems	2	2	15	2	2	4
eyes	3	5	2	3	12	5
ears, nose, throat	1	4	5	7	3	4
bones-muscles	3	11	8	6	22	9
arthritis-rheumatism	10	2	1	3	2	5
allergies	2	1	2	2	0	2
emotional-mental	0	0	1	2	2	1
infant-childhood	0	0	1	0	0	0
miscellaneous	7	11	12	5	14	9
Total	101%	99%	102%	100%	101%	100%
(N)	(232)	(179)	(93)	(131)	(96)	(731)

Table 9. Was help sought? (for health problem sample)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
Yes	87%	88%	92%	92%	86%	89%
No	13	12	8	8	14	11
Total	100%	100%	100%	100%	100%	100%
(N)	(231)	(176)	(91)	(131)	(95)	(724)

Table 10. If help not sought, why? (for health problem sample)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
high cost	29%	29%	38%	0%	28%	25%
language problem	33	4	25	0	33	23
transportation problem	10	18	3	8	15	10
complicated procedure	0	7	6	22	3	6
did'nt know where	23	25	28	65	20	30
never thought of	2	4	0	3	3	2
too much trouble	1	7	0	0	0	1
embarrased to ask	2	4	0	0	0	1
refuse to use welfare	0	4	0	3	0	1
Total	100%	102%	100%	101%	102%	99%
(N)	(93)	(28)	(32)	(37)	(40)	(230)

Table IIa. If sought help, did you encounter any difficulty?
(for health problem sample)

Difficulty	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
Yes	47%	26%	34%	36%	58%	39%
No	54	74	66	64	42	61
Total	101%	100%	100%	100%	100%	100%
(N)	(198)	(156)	(85)	(120)	(81)	(640)

Table 11b. Difficulties encountered in seeking help: (for health problem sample)

Difficulties	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
high cost	97%	98%	100%	96%	93%	97%
language problem	1	2	0	4	2	2
transportation problem	2	0	0	0	2	1
complicated procedure	1	0	0	0	0	0
did'nt know where	0	0	0	0	2	0
Total	100%	100%	100%	100%	99%	100%
(N)	(114)	(45)	(39)	(48)	(45)	(291)

Table 12. Source of help by ethnicity (Chinese, Japanese, and Pilipino only; for health problem sample)*.

	Chinese	Japanese	Pilipino	Row Total
practitioner only	50%	61%	12%	44%
facility only	31	13	45	28
both practitioner and facility	19	26	43	27
Total (N)	100% (201)	100% (165)	100% (120)	99% (468)

* for df=4 chi square=96.42, significant at 0.001 level.

Table 13. Sources of help by ethnicity.
(All ethnic groups; health problem sample)*

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
Practitioner only	50%	61%	7%	12%	9%	35%
Facility only	31	13	5	45	6	23
Both practitioner and facility	19	26	88	43	85	43
Total	100%	100%	100%	100%	100%	101%
(N)	(201)	(165)	(85)	(120)	(82)	(653)

* for df=8 chi square=274, significant at 0.001 level.

Table 14. Facility use pattern by ethnicity.
(for Chinese, Japanese, and Pilipino only; health problem sample)*

	Chinese	Japanese	Pilipino	Row Total
Hospitals	82%	92%	76%	82%
Non-hospitals	18	8	24	18
Total	100%	100%	100%	100%
(N)	(101)	(64)	(106)	(271)

* for df=2 chi square=6.81, significant at 0.05 level.

Table 15. Facility use by ethnicity.
(for Chinese, Japanese, Pilipino only; health problem sample)*

	Chinese	Japanese	Pilipino
Inpatient	37%	64%	29%
Outpatient	46	28	47
Non-hospital	18	8	24
Total	101%	100%	100%
(N)	(101)	(64)	(106)

* for df=4, chi square=22, significant at 0.001 level

Table 16. Facility use by ethnicity. (for Chinese, Japanese, and Pilipino only; health problem sample)*.

	Chinese	Japanese	Pilipino
Hospital inpatient	37%	65%	29%
Hospital outpatient	46	28	47
Health center	4	2	5
Community health center	2	0	18
Others	12	6	1
Total	101%	101%	100%
(N)	(101)	(64)	(106)

Table 17. Is anyone in your family covered by insurance?
(for families that have health problem)

Covered by insurance?	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
Yes	82%	96%	59%	75%	88%	82%
No	18	5	41	25	13	18
Total	100%	101%	100%	100%	101%	100%
(N)	(232)	(179)	(93)	(131)	(96)	(731)

Table 18. Method of payment. (health problem sample)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row
Insurance	34%	65%	34%	49%	78%	49%
borrowed money	0	1	0	0	4	0
saving.	62	27	58	12	9	37
still owe for care	0	1	0	3	6	2
free	3	2	6	19	3	6
others	2	3	1	19	1	5
Total	101%	99%	99%	102%	101%	99%
(N)	(190)	(147)	(83)	(119)	(78)	(617)

TABLE 19. Types of health insurance. (health problem sample)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
voluntary health insurance	48%	25%	43%	41%	23%	33%
group medical plan	15	16	31	28	34	22
commercial health insur.	3	6	7	2	2	3
medical assistant	13	12	11	8	28	14
medicare for person	22	40	2	15	7	21
other	0	1	1	8	5	2
Total	101%	100%	100%	102%	99%	101%
(N)	(232)	(179)	(93)	(131)	(96)	(731)

Table.20. How was service discovered? (health problem sample)

	Chinese	Japanese	Korean	Pilipino	Samoan	Row Total
friends	72%	19%	45%	50%	23%	48%
relatives	12	29	17	20	38	21
public media	1	7	11	2	4	4
Asian vernacular	1	5	1	0	0	1
doctor	2	36	16	3	28	13
nurse	0	0	0	0	1	0
out reach worker.	3	0	1	1	1	2
other	9	4	9	24	4	11
Total (N)	100% (192)	100% (93)	100% (82)	100% (117)	99% (74)	100% (558)

Table 21. How was Service discovered?
By sex; All five ethnic groups in health problem sample.*

	Male	Female	Row Total
Friends	52%	36%	44%
Relatives	16	34	25
Public Media	5	2	4
Asian Vernacular	1	2	2
Doctor	12	17	15
Nurse	2	0	0
Outreach worker	2	1	2
Others	12	6	9
Total	102%	98%	101%
(N)	(414)	(144)	(558)

*for df=7 chi square=31, significant at 0.001 level.

Table 22a. How was service discovered?
By sex; for Chinese Japanese, and Pilipino in health problem sample.

	Chinese		Japanese		Pilipino	
	Male	Female	Male	Female	Male	Female
Friends	74%	64%	24%	14%	50%	51%
Relatives	9	24	24	36	15	31
Public Media	1	3	10	2	1	3
Asian Vernacular	1	0	4	7	1	3
Doctor	2	3	37	33	4	3
Outreach worker	3	3	0	0	1	0
Others	10	3	2	7	29	11
Total	100%	100%	101%	99%	101%	102%
(N)	(159)	(33)	(51)	(42)	(82)	(35)

Table 22b. How was service discovered?
(By sex; for Koreans and Samoans in health problem sample)

	Korean		Samoan	
	Male	Female	Male	Female
Friends	45%	46%	26%	14%
Relatives	13	39	34	48
Public Media	13	0	6	0
Asian Vernacular	1	0	0	0
Doctor	17	8	24	38
Nurse	0	0	2	0
Outreach worker	1	0	2	0
Others	9	8	6	0
Total	99%	101%	100%	100%
(N)	(69)	(13)	(53)	(21)

Table 23. Year Medical Checkup.
(Comparing non-health problem sample with health problem sample).*

	Non-health problem sample	Health problem sample
Last year	42%	51%
1-6 year	43	34
6 years or +	3	5
Never	11	10
Total	99%	100%
(N)	(878)	(728)

*for df=3 chi square=20.6, significant at 0.01 level.

Table 24. Year Eye Checkup.
(comparing non-health problem sample with health problem sample)*

	Non-health problem sample	Health problem sample
Last year	27%	26%
1-6 year	35	31
6 year or +	3	5
Never	34	39
Total (N)	99% (878)	101% (729)

* for df=3 chi square=6.6, not significant at 0.05 level.

Table 25. Year Dental Checkup.
(Comparing non-health problem sample with health problem sample).*

	Non-health problem sample	Health problem sample
Last year	32%	29%
1-6 year	37	34
6 years or +	5	8
Never	26	29
Total (N)	100% (878)	100% (729)

* for df=3 chi square=9.1, significant at 0.01 level